# Dental Treatment consent

- I hereby authorize the dentist, assistants or dental hygienists to take x-rays, impressions, study models, and other diagnostic aids deemed appropriate by the dentist to make a diagnosis of your child (name of patient) _____ dental needs.

- I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

- I consent to the administration of anesthetics and other medications as may be considered necessary and advisable by the dentist. I understand that there are risks and benefits that may occur and are possible in the performance of any procedure. I can ask for an explanation of possible risks and benefits.

- I give consent to the dentist's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations.

- I understand that students in dental care professions may be present or participate in my care under supervision. I also understand, that in the event there is a need for technical support concerning dental equipment or dental supplies, representatives required for that purpose may need to be present in the operatory or procedure room. I consent to their presence.

- I acknowledge that I am responsible and I hereby agree to pay for the services provided to me or my dependents by Lucky Kids Dental, PC. I understand that payment or co-payment is due at the time of services, unless other arrangements have been made.

This consent is effective for 12 months from the date of signature below.

_____ _____/_____/_____

Patient signature (Person authorized to consent for patient) Date (month/day/year)

_____ _____/_____/_____

Witness Date (month/day/year)